American College of PHLEBOLOGY
advancing vein care

ACP PRECEPTORSHIP
Trainee Application

Contact Information
Please type of print clearly.

First, Mid and Last Name: _____

Company: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email (Required): _____

Phone: _____ Fax: _____

Medical License Number, State & Expiration Date _____

Medical School: _____ Residency: _____

Board Certified: ☐ Yes ☐ No Certification: _____ Recertification Date: _____

How were you referred to the preceptor program ☐ ACP Member ☐ ACP Website ☐ Internet Search ☐ Other _____

I am a: ☐ Physician (MD or DO) ☐ Physician's Assistant ☐ Nurse ☐ Other (please specify)

Have you performed any of the following? If YES, how long have you been performing each (years/months):

Procedure			Yrs./Mos.	Procedure			Yrs./Mos.
☐ Basic Venous Ultrasound and Surface Sclerotherapy	☐ Yes	☐ No		☐ Ultrasound Guided Sclerotherapy	☐ Yes	☐ No	
☐ Cutaneous Laser Therapy	☐ Yes	☐ No		☐ Endovenous Ablation	☐ Yes	☐ No	
☐ Sclerotherapy	☐ Yes	☐ No		☐ Ambulatory Phlebectomy	☐ Yes	☐ No	
☐ Venous Ultrasound	☐ Yes	☐ No		☐ Other Vein Procedures	☐ Yes	☐ No	

Other Information Required with Application
Submit this form with explanations for the following items in a separate Word or PDF document:

1. Please provide a list of phlebology related meetings attended in the last three years.
2. Expected goals and training interests.
3. Preferred training dates and length of program.

☐ I declare under penalty of perjury under the laws of the State of California that the above information and all attachments are true and correct. I understand that I am financially responsible to pay the preceptorship fees described in ACP's program materials and all travel expenses.